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No. 94-1094

In The

Supreme Court of the United States

October Term, 1994

ROBERT B. REICH, SECRETARY OF LABOR,

Petitioner,

v.

CONTINENTAL CASUALTY COMPANY and AMERICAN CASUALTY COMPANY OF READING, PENNSYLVANIA,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

RESPONDENTS' BRIEF IN OPPOSITION

GARY M. ELDEN
(Counsel of Record)
DONALD A. VOGELSANG
MICHAEL W. EARLY
CHRISTOPHER R. HILL
GRIPPO & ELDEN
227 West Monroe Street
Suite 3600
Chicago, Illinois 60606
(312) 704-7700

Attorneys for Respondents

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

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RESTATEMENT OF QUESTIONS PRESENTED

1. Whether ERISA affirmatively authorizes a cause of action against a nonfiduciary on the basis that the nonfiduciary knowingly participated in a fiduciary's breach of duty.

2. Whether the relief sought by the Secretary in this case was equitable.

STATEMENT OF CORPORATE RELATIONSHIPS

CNA Financial Corporation is the parent corporation of Continental Casualty Company, which in turn is the parent corporation of American Casualty Co. of Reading, Pennsylvania. Continental Casualty also owns 90.6% of Agency Management Services, Inc. American Casualty Co. has no non-wholly owned subsidiaries.

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COUNTER-STATEMENT

This claim was based on the tenuous concept that a nonfiduciary insurance company can somehow be liable under ERISA for entering into an arms-length settlement of a lawsuit brought against it by plan trustees. Because the facts demonstrate why the Court's views in *Mertens v. Hewitt Assocs.*, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993), were correct, and because they also show that this case was one for damages barred even by the Court's ultimate holding in *Mertens*, Respondents provide this counter-statement.

A. Policy And Cancellation

Respondents Continental Casualty Company and American Casualty Company of Reading, Pennsylvania do business under the service mark "CNA." In 1978, CNA began providing fiduciary liability insurance to the trustees of the Hotel Employees and Restaurant Employees International Union Welfare and Pension Plans (the "Plans"). (A. 37.)[1] In October 1984, CNA issued a renewal policy for a term of three years and annual limits of $5 million. (A. 37, 199-205.) It was a "claims-made" policy, providing coverage for "wrongful acts" of the insureds as long as the claim was first made during the policy period. (A. 37, 145-162.)

Before July 1985, CNA was already paying for the defense of the insureds in a claim entitled *Cullerton v.*

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[1] References to "A" are to the appendices of the record filed in the appellate court.

Liever in Las Vegas. (A. 38.) In July 1985, the Secretary filed an ERISA claim against the insureds and others in New Jersey, entitled *Brock v. Gerace* (the "*Gerace* claim"). (A. 38-39, 130-44.) Because of adverse claims history, the insurance agent sent notice of cancellation, effective October 17, 1985, the end of the first year of the policy. (A. 39, 127.)

The policy contained an "extended reporting option" which could be exercised only upon cancellation. The trustees exercised that option, under which coverage would be extended for one year for claims made during that year but only if the "wrongful acts" occurred before the initial date of cancellation. The net effect was that the trustees had no coverage for any actions they would take after October 17, 1985. (A. 39-40, 117, 146.)

B. The Coverage Action

The Plans governing declaration of trust required fiduciary liability insurance to be in place. (A. 222.) Counsel for the Plans informed the trustees it was necessary to have insurance in place. (A. 316-18, 92, 101-03.) Throughout the fall of 1985, the trustees searched for replacement coverage but found none. (A. 50, 333, 344-48.) The market for such insurance had collapsed. Those who could buy it were paying greatly increased premiums and those with an adverse claims history could not buy it at any price. (A. 257-58, 286, 295, 346-49.) The Secretary stipulated that replacement insurance was not available to these trustees anywhere in the world. (A. 50, 348-49.) Management trustees considered resigning if insurance was not found

(A. 92, 289-90, 319), and voting on important plan business was deferred while the search was conducted. (A. 90.)

On December 16, 1985, the trustees sued CNA in Illinois state court (the "Coverage Action"), seeking to compel CNA to reinstate the insurance based primarily on the theory that the notice of cancellation sent was ineffective under Illinois law because it did not specify the reason for cancellation. (A. 40.) The state court issued a temporary restraining order requiring CNA to provide insurance during the term of the order. The court did so despite expressing doubts as to the ability of the trustees to succeed on the merits and despite a directly opposite state appellate decision precluding such relief. *Kessler v. Continental Casualty Co.*, 132 Ill. App. 3d 540, 477 N.E.2d 1287 (1985). (A. 41, 95-97, 230.) The parties' counsel began settlement discussions which continued into early 1986, during which time the TRO was continued by agreement. (A. 41.)

C. Settlement Agreement

Throughout this period, CNA dealt only with the trustees' counsel (A. 41-42, 311), who insisted that any settlement had to involve reinstatement of coverage. CNA was reluctant to do so but eventually acceded. (A. 304-05, 273, 282.) A point of concern in the negotiations was the *Gerace* claim. The trustees' counsel asserted that the *Gerace* claim had no merit, and he had written an opinion letter to that effect. (A. 231-33, 277-78, 283-84, 327.) The idea arose for a settlement to pin future coverage on the costs of the *Gerace* claim. An initial settlement

agreement was negotiated and then rejected by the trustees. (A. 41-42, 104-05, 106-16.)

The parties then reached a settlement agreement similar to the first. The trustees agreed to pay an additional premium of $970,000. CNA agreed to issue an endorsement to the policy rescinding cancellation and reinstating coverage for the period October 1985-87. The limits applicable to those last two years of the policy would be $2 million combined defense and indemnity subject to a reduction of up to $1 million based on the costs of the *Gerace* claim. (A. 42-43, 118-126, 117a-117b.) The effect was that at least $1 million of insurance would be available for future acts and claims, and more would be available if the *Gerace* claim ended up costing any amount less than $1 million. (A. 117a-117b.) By the time the agreement was finally signed by all, CNA had spent about $300,000 in *Gerace*. (A. 210.) On March 27, 1986, the state court entered an order dismissing the coverage claim against CNA, which then issued the agreed endorsement ("Endorsement No. 7") to the policy. (A. 43-44, 117a-117b, 163.)

D. Subsequent Events

In May 1986, the Secretary filed another ERISA claim against the trustees and others in Nevada, *Brock v. Hanley* (the "*Hanley* claim"). (A. 46.) CNA began defending under the terms of Endorsement No. 7. That claim asserted wrongful acts of the trustees occurring before October 1985 *and* wrongful acts occurring after October 1985, *i.e.*, acts for which coverage would not have existed but for Endorsement No. 7. (A. 167-89.)

In the fall of 1986, the Secretary learned of Endorsement No. 7 and subpoenaed documents relating to it and interviewed witnesses. (A. 47, 234-36, 48-49, 329-31.) The *Gerace* and *Hanley* claims continued in litigation until 1988, at which time they were settled through negotiations with the Secretary. (A. 48, 190-93, 194-96.) By that time, CNA had spent more than $1 million in defense costs in *Gerace*. (A. 47-48.)

Pursuant to the settlement of the *Gerace* and *Hanley* claims, CNA paid a total in indemnity for the trustees of $2.8 million ($1.95 million for *Gerace*, and $850,000 for *Hanley* under Endorsement No. 7). (A. 48, 237, 238.) That money went to the Plans. (A. 190-93, 194-96.) In addition, CNA paid out $2.27 million in defense costs for *Gerace* and $132,900 for *Hanley*. (A. 237, 238.) Thus, for a total policy premium of about $1 million, CNA paid out more than $5 million, including $982,900 under Endorsement No. 7.

When CNA's insurance expired in 1987, the trustees were able to acquire from other insurers a one-year replacement policy with combined defense and indemnity limits of $2 million and a premium of $750,000. (A. 239-40). That policy precluded coverage for any wrongful acts that occurred before its issuance. (A. 239-40.) As a result, it provided significantly reduced coverage in comparison to CNA's policy which had provided prior acts coverage.[2]

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[2] *See Truck Ins. Exchange v. Ashland Oil, Inc.*, 951 F.2d 787, 791 (7th Cir. 1992) (recognizing that exclusion of prior acts coverage in such insurance substantially reduces its value).

E. The Current Action

Despite knowing of the events concerning the settlement of the Coverage Action, the Secretary did not attempt to bring a claim against CNA until after the Secretary had settled the *Gerace* and *Hanley* claims, *i.e.*, until after CNA had paid $2.8 million to the Plans under the terms of the policy with Endorsement No. 7.

In October 1989, the Secretary filed the current ERISA claim against CNA and the trustees. The Secretary conceded CNA was not a "fiduciary" as defined in ERISA. (A. 10, 36, 61-67.) Following discovery, the district court entered a final pre-trial order, which superseded anything in the complaint, *e.g.*, *Franklin v. United States*, 992 F.2d 1492, 1497 (10th Cir. 1993), and contained the theories and relief the Secretary was actually pursuing. The Secretary settled with the trustees under an agreement which required the trustees to pay *nothing*. (A. 86-87.) The case then proceeded through a partial trial.

According to the Secretary's submissions in the final pre-trial order, the relief he was seeking was to recover the "losses to the Plans." (A. 68-69, 63, 73.) The submissions mention "restitution" but only in the phrase "restitution . . . for all losses to the Plans." (A. 73.) The Secretary sought recovery of the entire $970,000 premium plus interest. (A. 63-65, 68-69, 73-74.)[3] The Secretary did

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[3] In its petition, the Secretary attempts to rely on the relief allegations asserted in the complaint to show he was seeking equitable relief. (Secretary's Petition at 6.) The final pre-trial order controlled this case and in that order the Secretary made it clear he was seeking monetary relief to recover the "losses to the Plans," *i.e.*, damages.

not mention any of the usual concepts of restitution, such as that he was seeking to recover the profits CNA had made (which were none), that he was offering the return of any insurance amounts CNA had paid or to allow their deduction from the $970,000, or that the parties should otherwise be put back into the position they were in before the settlement of the Coverage Action. In fact, the Secretary asserted that whether CNA made a profit was irrelevant to the case because he was seeking the losses to the Plans. (A. 268-69.) The district court entered an order precluding the Secretary from arguing that CNA had profited from the transaction. (A. 88-89, 75-81.)

The crux of the Secretary's theory of liability was that, in hindsight, Endorsement No. 7 ended up providing only $1 million in future coverage for $970,000 in premium, and CNA violated ERISA by providing such insurance. (A. 53, 57.) The Secretary conceded like insurance could not have been purchased elsewhere for less. (A. 50, 348-49.) Also, the Secretary's expert would not give the opinion that the amount of the premium was unreasonable. (A. 88-89, 75-81.) According to the Secretary, the trustees, when they were considering entering into the settlement of the Coverage Action, did not adequately investigate the potential effects of the settlement and were acting in the interest of protecting themselves from future liability rather than in the interest of the Plans. (A. 53, 56-58, 72-73.) CNA, which dealt only with the trustees' counsel in those settlement negotiations and thus had no knowledge of what the trustees actually did or considered (A. 41-42, 311), somehow "knowingly" participated in the breach. The Secretary contended CNA could be charged with knowledge of a breach because it

knew it was dealing with trustees and had received Plan assets and should have known the premium was close to the policy limits. (A. 61-62, 68, 73.)

During a break in the trial, the Court decided *Mertens v. Hewitt Assocs.*, 113 S.Ct. 2063 (1993). The district court requested briefing on its impact and the Secretary submitted a brief attempting to change his trial theory of relief by alleging he would seek recovery of $818,107 by allowing deductions for some fees and expenses to the $970,000 premium. Relying on the dictum in *Mertens* that nonfiduciaries cannot be sued for participation in a fiduciary breach, the district court dismissed the case and the appellate court affirmed.

REASONS FOR DENYING THE PETITION

The Court should deny review for two reasons. First, the view expressed by the majority of the Court in *Mertens v. Hewitt Assocs.*, 113 S.Ct. 2063 (1993) (hereinafter "*Mertens*"), that nonfiduciaries cannot be sued under ERISA for knowing participation in a fiduciary's breach, does not need to be revisited because: (a) the Court actually considered and rejected the ERISA arguments the Secretary is now making for seeking review, not only in relation to the dictum in *Mertens*, but also in relation to the Court's ultimate holding; (b) the Court itself has relied on and reaffirmed its views in *Mertens* in *Central Bank of Denver v. First Interstate Bank of Denver*, 114 S.Ct. 1439, 128 L.Ed.2d 119 (1994); and (c) there is currently no division among the circuits as to the impact of *Mertens*. Moreover, the facts of this case demonstrate why courts

should not read into ERISA duties and causes of action not expressly provided for.

Second, though the appellate court did not ultimately rule on the issue, this case was one seeking damages and not traditional equitable relief.[4] Thus, the claim is controlled by the Court's ultimate holding in *Mertens* that such relief is not available under ERISA from nonfiduciaries.

I.

REVIEW OF THE *MERTENS* DICTUM IS NOT NECESSARY

A. The Secretary's Current ERISA Arguments Were All Rejected In *Mertens* And The Secretary Offers Nothing New

The Secretary's arguments for construing ERISA to allow claims against nonfiduciaries for knowing participation in a fiduciary breach were all briefed in *Mertens* and rejected, not only in relation to the dictum in *Mertens* but also in relation to the Court's ultimate ruling precluding damages claims. The Court, in relation to the damages holding expressly rejected the Secretary's arguments here: (a) that claims which existed under the common law of trusts should be read into ERISA; (b) that ERISA's

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[4] The Secretary contends the appellate court agreed that the actual relief he was seeking "in this case" was restitution for the "unjust avoidance of a loss." (Secretary's Petition at 8.) In fact, the appellate court questioned whether restitution was the relief being sought, and ultimately avoided deciding the issue. *Reich v. Continental Cas. Co.*, 33 F.3d 754, 756-57 (7th Cir. 1994) (included in Secretary's Petition, Appendix A at 5a-6a).

purpose to protect plan beneficiaries would be thwarted if common law claims are not recognized; (c) that broad preemption requires broad protection because otherwise beneficiaries will end up with less protection than under the common law; and (d) that the "federal common law" can be used to read into the statute duties and claims not expressly provided for. 113 S.Ct. at 2068-72. The Court also rejected the Secretary's argument that section 502(l), 29 U.S.C. § 1132(l), indicates that claims against nonfiduciaries are allowed, by holding section 502(l) could be construed to be consistent with a finding that nonfiduciaries cannot be sued. 113 S.Ct. at 2070-71.

The Secretary provides nothing to challenge the impeccable reasoning of the Court for its belief that nonfiduciaries cannot be sued at all for knowing participation in a fiduciary breach. As the Court noted, no provision of ERISA creates a duty to avoid such participation by nonfiduciaries, though such a duty is created for cofiduciaries. 113 S.Ct. at 2067. The equitable remedies provisions of ERISA, 29 U.S.C. § 1132(a)(3) and (5), only allow such relief to redress violations of other provisions of ERISA. Since nonfiduciaries are not covered by the fiduciary duty provisions, they cannot violate them. *Id.* ERISA provides a broad definition of "fiduciary," which includes many, but not all, common law nonfiduciaries. Thus, as the Court said, the absence of a claim against nonfiduciaries appears deliberate. *Id.*

Thus, all the ERISA arguments the Secretary raises in his petition were raised and rejected in *Mertens* and the Secretary provides no new grounds for having the Court reconsider what it said.

B. The Court Has Already Relied On And Reaffirmed Its Views In *Mertens*

In *Central Bank of Denver v. First Interstate Bank of Denver*, 114 S.Ct. 1439 (1994), the Court held that aiders and abettors cannot be liable under section 10(b) of the Securities and Exchange Act, 15 U.S.C. § 78j, because the section does not expressly create liability for such persons (*i.e.*, the same issue involving nonfiduciaries under ERISA). In so holding, the Court relied partly on *Mertens*, stating:

> Last Term, the Court faced . . . a case *raising the question whether knowing participation in a breach of fiduciary duty is actionable under ERISA. Mertens* . . . The petitioner in *Mertens* said that the knowing participation cause of action had been available in the common law of trusts and should be available under ERISA. *We rejected that argument* and noted that no provision in ERISA "explicitly require[d] [nonfiduciaries] to avoid participation (knowing or unknowing) in a fiduciary's breach of fiduciary duty." *Id.* . . . 113 S.Ct., at 2067. While plaintiffs had a remedy against nonfiduciaries at common law, that was because "nonfiduciaries had a *duty* to the beneficiaries not to assist in the fiduciary's breach." *Id.* . . . 113 S.Ct., at 2068, n. 5. No comparable duty was set forth in ERISA.

Central Bank, 114 S.Ct. at 1447 (some emphases added) (citations partially omitted).

Thus, the Court has already made it clear it meant what it said in *Mertens* and additional review is not needed.

C. The Circuits Are Not Divided

There is currently no division among the circuit courts as to the impact of *Mertens* and thus no need to take review at this time. The Secretary's petition itself concedes the circuits have thus far been consistent on *Mertens* and the trend is to follow the dictum. (Secretary's Petition at 11-12.) What the Secretary requests is for the Court to resolve a division of the circuit courts that existed before *Mertens*. The Court should instead wait until other circuits have reconsidered their prior holdings in light of *Mertens* and *Central Bank* and then determine whether further review of the issue is necessary. *See McCray v. New York*, 461 U.S. 961, 962, 103 S.Ct. 2438, 2439, 77 L.Ed.2d 1322 (1983) (opinion of Stevens, J., respecting denial of cert.) (noting that "further consideration . . . of the problem by other courts will enable us to deal with the issue more wisely at a later date.")

D. This Case Demonstrates Why The Court's Views In *Mertens* Are Correct

CNA was sued because the Secretary did not like the result of an arms-length settlement agreement of a lawsuit. The crux of the Secretary's case is that it is wrong to charge a premium close to limits for insurance. However, the Secretary had no evidence to show the amount of the premium was unreasonable. Moreover, as courts have recognized, premiums for liability insurance in the commercial market are often close to the amount of insurance provided. *Sears, Roebuck & Co. v. Commissioner*, 972 F.2d 858, 862 (7th Cir. 1992).

The Secretary's theory was that the trustees, when they were considering the settlement, did not adequately investigate its potential effects and were considering their own interest to prevent future liability rather than the interests of the Plans. CNA, which dealt only with the trustees' counsel in the settlement negotiations, can somehow be sued as a "knowing" participant in that breach despite having no knowledge of what the trustees actually did or considered. By the time of trial, the Secretary was arguing for a "constructive knowledge" standard under ERISA, contending CNA could be charged with knowledge of the trustees' breach simply because it knew it was dealing with trustees and that plan assets were transferred.

The Secretary was able to present this theory only because of the complete absence of any ERISA standards applicable to this claim. Though "cofiduciaries" under ERISA are liable for knowing participation in another fiduciary's breach only upon a showing of actual knowledge of the breach, 29 U.S.C. § 1105(a)(1), some pre-*Mertens* courts had gone so far as to hold that nonfiduciaries can be liable merely by proving the constructive knowledge theory the Secretary asserted. *E.g., Donovan v. Schmoutey*, 592 F.Supp. 1361, 1395-96 (D. Nev. 1984). In essence, nonfiduciaries could be sued even under circumstances that cofiduciaries could not.

Other courts took the view that the common law requires actual knowledge of the breach. *See, e.g., Pension Benefit Guaranty Corp. v. Ross*, 781 F.Supp. 415, 418 (M.D.N.C. 1991). What the pre-*Mertens* cases demonstrate is that the standard of scienter to be applied to nonfiduciaries varies at common law. A view that common law

duties can be read into ERISA when ERISA provides no standards for them means parties like CNA are left in the dark as to standards applicable to them, particularly since the common law itself differs from jurisdiction to jurisdiction, and allows parties like the Secretary to make whatever argument they want to fit a particular case. The facts of this case thus demonstrate why the Court's views in *Mertens* are correct. ERISA contains nothing to indicate that a nonfiduciary can somehow violate its provisions by entering into an arms-length settlement of a lawsuit. The Secretary was able to create and pursue this otherwise meritless case only because some courts had been engaging in the unwise practice of reading into ERISA all of the common law of trusts, which law is itself diverse.

II.

REVIEW SHOULD NOT BE GRANTED BECAUSE THIS WAS A CASE FOR DAMAGES

The Court should avoid further review of this case because the Secretary was not seeking traditional equitable relief of "restitution" but instead was seeking damages. The case is thus controlled by the Court's ultimate holding in *Mertens*.

In the controlling final pre-trial order, the Secretary made it clear that he was only seeking "the losses to the Plans" and wanted CNA to pay $970,000 plus interest. As the Court in *Mertens* recognized, seeking monetary relief for "losses [the] plan sustained" is a claim for damages. 113 S.Ct. at 2068. Labeling it "restitution" does not make it so.

Restitution is a claim to recover the profits made by a defendant from a wrongful act. *E.g., Parks v. Pavkovic*, 753 F.2d 1397, 1408 (7th Cir.) (amount of restitution is measured by "profit" made by defendant, not loss sustained by plaintiff), *cert. denied*, 473 U.S. 906 (1985), and *cert. denied*, 474 U.S. 918 (1985). CNA made no profit from the transaction involved here (it lost millions) and the district court ruled the Secretary could not even argue that CNA had profited from the transaction.

Moreover, restitution was not available as a remedy here. This case involved a contract, the settlement agreement for the Coverage Action, in which both sides gave consideration. Restitution is unavailable in such circumstances absent rescission of the contract and return to the *status quo ante*, *i.e.*, the consideration given by the defendant must be returned or its value deducted from the plaintiff's recovery. *E.g., Myzel v. Fields*, 386 F.2d 718, 741-42 (8th Cir. 1967), *cert. denied*, 390 U.S. 951 (1968); *Hogan v. Wright*, 356 F.2d 595, 598 (6th Cir. 1966); *Chris-Craft Indus. Inc. v. Piper Aircraft Corp.*, 480 F.2d 341, 391 (2d Cir.), *cert. denied*, 414 U.S. 910 (1973), and *cert. denied*, 414 U.S. 924 (1973). The Secretary never actually sought rescission and never offered to restore the parties to the *status quo ante* – to do so would have resulted in no recovery.

Also, restitution is not available if circumstances have so changed that it would be inequitable to require a defendant to make restitution. D. Dobbs, *Remedies* § 4.6 (1973). Relying on the policy with Endorsement No. 7, CNA provided coverage for the *Gerace* and *Hanley* claims and ended up paying the Plans $2.8 million in relation to the settlement for those claims. The Secretary, who negotiated those settlements, knew of the events that gave rise

to this claim long before those cases were settled. Instead of pursuing an immediate suit, the Secretary waited until after CNA had fully covered those claims and then sued to challenge the very agreement under which such coverage was provided.

By the time this case was filed, circumstances had so changed that it would have been inequitable to allow restitution. It was not possible to undo all the transactions that flowed from the issuance of Endorsement No. 7 and it was not possible to return the parties to the position they were in before the settlement of the Coverage Action.

Finally, the Secretary's attempt, after *Mertens* was decided, to change his theory of recovery to seek $818,107 by allowing some setoffs did nothing to change this case into one for "restitution." His new theory was still one for damages. A true restitutionary theory would have looked at the settlement agreement of the Coverage Action to evaluate it as to whether unjust enrichment occurred at the time it was entered into, *i.e.*, in this case, whether the amount of premium charged was unreasonable in relation to the value of the insurance CNA agreed to provide. *See Bausch & Lomb Inc. v. Bressler*, 977 F.2d 720, 730 (2d Cir. 1992) (when consideration given by defendant is the right to a future benefit, restitution is measured by the difference between the price paid and the market value of the right; the negotiated contract price is the best evidence of the right's value absent other readily obtainable evidence of market value). If a trustee wrongfully sells $1 million in trust property to a nonfiduciary but the nonfiduciary happens to provide $1 million in value in return, the nonfiduciary cannot possibly be unjustly enriched. The Secretary's own theory of this case conceded that CNA

gave at least $1 million in future insurance coverage (and then paid it out) in return for the $970,000 additional premium. The Secretary had no evidence to show the amount of premium was unreasonable. Thus, under any true restitutionary theory, CNA was not unjustly enriched.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

GARY M. ELDEN
(Counsel of Record)
DONALD A. VOGELSANG
MICHAEL W. EARLY
CHRISTOPHER R. HILL
GRIPPO & ELDEN
227 West Monroe Street
Suite 3600
Chicago, Illinois 60606
(312) 704-7700

Attorneys for Respondents

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